DOCUMENT RESUME

ED 203 231 CG 015 214

AUTHOR Greenberg, Jay: Doth, David
TITLE Financing Long Term Care. Selected Topics in Long Term Care. Volume 3.
INSTITUTION ELM Services, Inc., Washington, D.C.
SPONS AGENCY Administration on Aging (DHEW), Washington, D.C.
PUB DATE Sep 80
CONTRACT HEW-105-79-3008
NOTE 72p.: For related documents, see CG 015 212-217.

EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS Expenditures: *Federal Aid: Federal Programs: Financial Needs: Financial Problems: *Financial Support: *Fund Raising: *Grants: *Health Services: National Organizations: Older Adults: *State Aid
IDENTIFIERS *Long Term Care Facilities

ABSTRACT

This document, one in a series developed to provide technical assistance to 22 Long-Term Care Gerontology Centers, is designed to be a financial resource guide. Current major funding sources are detailed, followed by an examination of the issues and problems associated with current financing systems. Programmatic issues associated with Medicare and Medicaid are delineated as well as current patterns of long term care expenditures. Several sources of on-going, federal demonstration grants are briefly discussed. Additionally, a list of materials and national organizations useful in identifying demonstration and research funds is provided along with a bibliography of books, articles, and reports. (RC)

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HRP-0902773

ED203231

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Volume 3 in a Series:

Selected Topics in Long Term Care

September, 1980

Developed under
Administration on Aging
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICE
Contract No. HEW-105-79-3008

CG 015214

Selected Topics In Long Term Care

Volume 3

Financing Long Term Care

With an Essay by

Jay Greenberg, Sc.D.
and
David Doth, M.A.

Developed under
Administration on Aging Contract No. HEW 105-79-3008

September 1980

CG 0152 14

PREFACE

This document is one of a series developed by ELM Services, Inc. and a group of special consultants under Administration on Aging contract HEW-105-79-3008, a contract to provide technical assistance to twenty-two Long Term Care Gerontology Centers. The series, entitled Selected Topics in Long Term Care, contains five monographs with annotated bibliographies and additional resources. They are:

Volume 1: Models for Service Delivery for Long Term Care: An Introduction to the Literature, with an essay by Rosalie A. Kane, D.S.W. and Robert L. Kane, M.D.

Volume 2: Adult Daycare Services: An Introduction to the Literature with an essay by Richard A. Kalish, Ph.D.

Volume 3: Financing Long Term Care, with essay and bibliography by Jay Greenberg, Sc.D. and David Doth, M.A.

Volume 4: Program Evaluation and Evaluation Research: Theory, Issues and Applications Useful in Long Term Care Gerontology Centers, with an essay by David J. English, D.B.A. and Celia Berdes, M.S.P.H.

Volume 5: Education and Training Resources for Long Term Care Gerontology Centers, with an essay by Tom Hickey, Dr.P.H.

Each of the identified topics in the monograph series is integral to the Centers' basic mission of enhancing knowledge in long term care through policy research, increasing manpower in gerontology/-geriatrics, and/or providing technical assistance to communities in their regions.

The mandate of Long Term Care Gerontology Centers has been expressed by the Commissioner of the Administration on Aging, Robert Benedict:

> Comprehensive designation will be a recognition that these few centers have achieved a critical mass of intellectual talent, of community linkages, and of programmatic development across a wide variety of disciplines. Designation will serve as a measure of accomplishments pointing to these "centers of excellence" as those few institutions which are comprehensive programmatically in research, education and training, foremost in the creation of service laboratories

where assessment schemes, training and care with a multidisciplinary approach can be mounted, and in the development of key ties to community sites and service configurations.

Comprehensive gerontology centers will develop training teams, a cadre of experts to provide the nation and their regions with manpower through inter-disciplinary education and training efforts and continuing education programs.

They will develop research endeavors covering policy research, organizational design, human service system integration, economics and the whole range of validated assessment and evaluation tools we will need. They will include an emphasis on our data needs for the future.

Moreover, these centers will show strong linkages to communities and to the community service systems. Hand in hand, centers will provide the knowledge and technical assistance base for communities and especially community demonstrations.[1]

These Selected Topics in Long Term Care were chosen as the result of a survey of Long Term Care Gerontology Center directors conducted in the spring of 1980. Their focus was further refined at a conference which convened a team of experts in long term care and Long Term Care Gerontology Center grantees at Thousand Islands, New York in August of that year. (A list of conferees is included as an appendix.) The objective of both processes was to meet the needs of the twenty-two centers for guides to the state-of-the-art in key areas. The more general utility of the documents reflects the process by which they were created.

Participants in the Thousand Islands conference were asked to review an initial draft of a literature search and to apply their critical comments and knowledge of resources to the content and format of the documents. The mission presented to attendees was to assist in the creation of "functional" documents which could provide centers with both an overview of the theory surrounding a specific topic and a practical guide of "how-to" information.

Consultants and grantees initially discussed the specific information needs of Center grantees. Much of this discussion

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[1] From a speech before Long Term Care Gerontology Center grantees, February 1, 1980.

focused on the definition of the five topic areas and how information about them could be organized and presented to be of maximum use to the reader.

Each topic was then addressed by the conferees in general session. Specific subtopics were defined and further clarified in small working groups. Thus, by the end of the third day of the conference, the issues in each of the five topic areas had been identified and an approach to the presentation had been established.

The Conferees next dealt with subtopic areas, specifying key citations and fugitive information difficult to obtain but essential to an understanding of the state-of-the-art. In addition, they noted resource persons and organizations who, in the absence of literature, could provide key insights into each of the topics.

Subsequent to the Conference, ELM sought out and acquired the additional literature highlighted at the conference. In an attempt to provide the most current and advanced resources, the majority of the material cited is dated post-1975. Literature dated before that time has been cited if considered to be of special interest to centers. It has not been the intent of ELM to produce all-inclusive bibliographies, rather, the bibliographies have highlighted those portions of the literature whith appear to related to center functions or information needs.

ELM also asked individual consultants to utilize the collectively developed outlines to prepare state-of-the-art essays for each topic. These essays are intended to serve as guides to the literature.

An "Additional Resources" section has been developed by the ELM staff for four of the five monographs; the financing monograph is self-contained. Within these sections, resource persons have been identified, relevant organizations and associations have been listed, and additional bibliographies have been cited.

The resource persons have been identified through the collaborative efforts of project consultants and staff, by the extent of an individual's contribution to the literature, and finally, when agreements to be included as a resource person could be secured from the individuals themselves. The lists of resource persons are thus by no means exhaustive.

It is not intended that the role of resource persons will be to respond to every question germane to their stated field of specialization. Rather, they are to be utilized with discretion by the directors and staffs of Long Term Care Gerontology Centers when further direction or insight cannot be obtained through the literature or more readily available resources. Careful consideration should be given to the nature of a request and the time necessary to respond to that request. It should also be noted

that many of the resource persons are available for professional consultation.

A separate volume was developed (for distribution to Long Term Care Gerontology Centers only) consisting of single copies of selected articles. Articles have been selected for inclusion based on the significance of their contribution and the relative difficulty in obtaining copies. Readers may be able to obtain copies of these articles by contacting the centers. ELM also has copies of the majority of articles on file and may be able to provide single copies. A list of Long Term Care Gerontology Centers as of this date has been provided as an appendix.

ELM would like to express its appreciation for their assistance in the production of this series to all the attendees of the Thousand Islands conference. Deep appreciation must also go to Thomas Aschenbrener, the Project Officer on this technical assistance contract, for his assistance and supportive stance on innumerable occasions. Finally, ELM would like to express its appreciation to research staff members Celia Berdes, Kathleen Grady, Molly O'Connell Hart, Jane Armbruster-Hu and Patricia Berger-Friedman for their dedication and perseverance on this project.

David J. English, D.B.A.
Project Director

Lee E. Mortenson
Co-Project Director

TABLE OF CONTENTS

I. Introduction.

II. Major Federal Programs Which Affect the Elderly and the Chronically Ill

III. Issues Related to the Current System of Financing Long Term Care

IV. Recent Proposals to Develop Alternative Financing Strategies for Long Term Care Services

V. Sources of Funding for Demonstration Projects.

VI Annotated Bibliography

VII. Bibliography

VIII. Footnotes

SECTION I

INTRODUCTION

As Long Term Care Gerontology Centers move from their planning phase to operational entities, they will hopefully play a central role in improving the long term care delivery system in their state and community. Much of this work will involve the development of new and creative services and service delivery mechanisms. However, in order for these new services to become a reality, sources of financing must be found to pay for them. It is therefore essential that the staff of the Centers know and understand existing funding programs. Furthermore, an understanding of the problems and shortcomings of the existing system is essential to the development of proposals designed to cure the ills of the current system.

The primary objective of this chapter is to provide the Centers with a resource that will aid them in their quest for this needed information. The text begins with a fairly thorough discussion of current major funding sources for long term care services. This discussion is by design more detailed than most overviews of programs. The current financing system consists of a complex and confusing array of programs. It is absolutely essential that the Centers have a mastery of the current system if they are to effect positive change. The length and detail of the section on programs reflects this need. Nevertheless, the program discussion presented here can only be considered an introduction to the subject. This is followed by an examination of the issues and problems associated with the current financing system. In this section we examine programmatic issues associated with Medicare and Medicaid as well as issues that are more systemic in nature. We argue that identifying programmatic issues is not enough. Rather, it is the manner and degree to which the pieces of systems fit together that will ultimately determine the systems' ability to meet the long term care needs of the elderly. This section concludes with a brief examination of the current pattern of long term care expenditures. This discussion illustrates, with dollar figures, many of the problems presented in the section. This is followed by a discussion of recent proposals for altering the existing financing system. The discussion includes recently proposed long term care legislation, the long term care elements of three major National Health Insurance proposals, and several new concepts that have been proposed.

Because there is a high probability that many Centers will ultimately be involved in service delivery demonstrations, we briefly describe several sources of on-going, Federal demonstration grants. In addition, we present a list of written materials and national organizations that we think will be useful in the Centers' search for demonstration and research funds.

The narrative is followed by a selected annotated bibliography that consists of 14 books, articles, and reports that we feel will be most useful to Centers in dealing with the issues surrounding the financing of long term care services. In addition to the selected annotated bibliography, we include a longer bibliography that consists of references that relate to the financing of services, but for one of several reasons were not considered as useful as those pieces that are annotated.

There are several topics that relate to financing that are not discussed or only briefly discussed in the chapter. While we spend a great deal of time discussing what kinds of services are payed for and the nature of the programs that pay for them, we deal only very briefly with the form that these payments take. That is, the topic of alternative forms of reimbursement is not much discussed. This was done for two reasons. First, it was felt that issues such as the impact of prospective versus retrospective reimbursement, the distributing of reimbursement adjusted for case mix, and the proper way to reimburse capital costs would not be as directly relevant to Long Term Care Gerontology Centers as the issues that are discussed. Second, Tynam and Schlemker of the Center for Health Services Research (University of Colorado) have recently finished an excellent review of policy issues and research findings that surround the reimbursement of long-term care services. Finally, we spend little time on the revenue side of financing issues. That is, questions such as "which form of taxation should be used to finance services?", are only briefly discussed. Here again, it was felt that these types of generic public finance issues are not high priority concerns of the Centers. The readers interested in pursuing these issues are referred to John F. Due's text, Government Finance.

SECTION II

MAJOR FEDERAL PROGRAMS WHICH AFFECT THE ELDERLY AND THE CHRONICALLY ILL

This section discusses Federal programs which affect the elderly and the chronically ill client. The focus is on Medicare, Medicaid, Title XX-Social Services, Veterans Administration (VA), the Older Americans Act and Housing programs. The selection of programs is intentionally broad and, while several are not in the immediate domain of long term care policy, we feel some familiarity with each of them is important.

Most of the programs involve Federal and state cooperation, with program specifics often determined on a state basis. The discussion here is limited to the basic features of the programs. More detailed discussions are annotated in the recommended readings section of this document.

A. MEDICARE

Medicare is a Federally operated health insurance program for the elderly and the chronically disabled created in 1965 as Title XVIII of the Social Security Act. The program has two parts: hospital insurance (Part A) and supplementary medical insurance (Part B). The program emphasis is on acute care services and on services connected with acute care episodes. As such, it is not a long term care service program, though it provides services to the elderly and the disabled.

1. Eligibility

Most persons aged 65 and over are eligible for the hospital insurance program. Eligibility is determined by the Social Security Administration (SSA) and depends on having the requisite number of quarters of participation in the Social Security retirement program. Part A eligibility is automatic with retirement benefits. Initial enrollment in Part B is likewise automatic, though the individual has the option of not participating.

Individuals ineligible for the program may voluntarily enroll in Part A if they enroll in Part B as well. In 1980, the premium for the voluntary program is $78 per month. There is also a monthly premium of $9.60 per month for Part B for all beneficiaries in the program. However, Section 1843 of Title XVIII allows the state to pay the monthly premium for certain needy individuals. The purchase agreement is called the Medicare buy-in and is discussed in the Medicaid section below.

2. Services

Medicare coverage is defined in terms of a benefit period. A benefit period begins when a covered person enters a hospital and ends when that person has not been in a hospital or skilled nursing faculty (SNF) for 60 consecutive days. Covered in each benefit period are: 90 days of hospital care; 100 days of SNF care; and 100 days of home health visits following a hospital stay of at least three days. If 90 hospital days are exhausted during a given benefit period, then the person may draw from 60 lifetime reserve days.[3]

Part A is financed through payroll taxes. However, there are deductibles for the insured. The deductible in 1980 is $180--a figure approximately equal to the average cost of one hospital day.[4] The Part A coverage applies to the "reasonable cost" of coverage as reported by the facilities. For the first 60 days of an inpatient hospitalization, the insured pays the single deductible of $180. For each day from 61 through 90, the insured pays $45 (one-fourth of the deductible figure). Finally, the coinsurance on each of the 60 reserve days is $90 (one-half of the deductible figure). Inpatient services covered are a semi-private room, meal, inpatient drugs, nursing services, supplies and equipment, and medical social services. This does not include any private duty nursing service, physician's charges, or any convenience services. The first three pints of blood are not covered and must be paid for or replaced. Coverage differs somewhat for psychiatric benefits.[5]

The cost sharing in a SNF also involves coinsurance. The first 20 days are without cost to the insured. For stays between 21 and 100 days, the cost sharing is daily coinsurance of $22.50 in 1980. There is no coinsurance for home health services in Part A. The home health benefit covers up to 100 days per benefit period. The visits must follow a three-day hospital stay or discharge from a SNF. A treatment plan must be developed within 14 days of the qualifying hospital or nursing home stay.[6] Services covered are intermittent nursing care, therapies, supplies and social services under a physician's direction, part-time home health aide, and intern or resident services from hospitals affiliated with a home health agency.

Part B medical services covered are:[7,8]

1. Physicians' services
2. Supplies and services related to physicians' care
3. Outpatient therapies (physical and speech therapy)
4. Diagnostic tests including x-rays
5. Surgical dressings
6. Prosthetics
7. Ambulance service
8. One hundred home health care visits (without the prior hospitalization)
9. Rural health clinic services

Part B may be used to pay for inpatient hospital services not covered under Part A. However, Part B excludes coverage for out-of-hospital drugs, private duty nursing in the hospital, eyeglasses, hearing aids, dental services, routine foot care, routine physical examinations, immunizations, and out-of-hospital psychiatric care in excess of $250.[9]

Part B requires that the individual meet a $60 deductible during any calendar year for covered services and a separate blood deductible or replacement. After the deductible is met, the program pays 80 percent of what are determined to be "reasonable charges." Home health care is reimbursed 100 percent by the program on the basis of reasonable cost or charges, whichever is less.

Physician payment under Part B is based on the reasonable and customary charge concept, which sets the charge at the 75th percentile of all customary charges for the service in a specific area. Typically, a physician files a claim and accepts the 80 percent payment from the Medicare carrier and the 20 percent from the insured. In this case, the physician is said to have "assigned" the claim and must accept the Medicare rate. The physician may, however, elect to be paid by the patient and seek payment above the Medicare allowable charge.[10] In this instance, the program share remains fixed at 80 percent of allowable charges, but the patient's cost share may increase considerably beyond the 20 percent.

In many instances, the program places other limits on the nature of the provider and the services. These restrictions are beyond the scope of this discussion.

B. MEDICAID

Medicaid is a Federal and State program that finances medical care for the poor and medically indigent. It is the main source of governmental funding for long term care services in the United States. In 1965, when Title XIX became part of the Social Security Act, it replaced medical coverage previously provided for under Old Age Assistance (OA), Aid to the Blind (AB), and Aid to the Permanant and Totally Disabled (AD). In 1972 the Supplemental Security Income Program (SSI) standardized these programs for the elderly and handicapped, providing a uniform definition of eligibility and a national cash assistance standard. The provisions of the SSI legislation guaranteed that no recipient group would be worse off after the legislation; many states instituted supplemental payments to maintain the same level of income that existed before the law.[11]

1. Eligibility

Medicaid eligibility is means tested and thus closely connected to client income and assets. There are two types of eligibility: categorical and medically needy. The first type is found in the

legislation which allows states to provide Medicaid coverage to one of three categories of individuals:

1. Persons receiving SSI,
2. Persons receiving SSI and an additional state supplement, and
3. Persons who meet eligibility standards lower than the Federal SSI level but not lower than the eligibility criteria used for medical assistance on January 1, 1972.

Additionally, the legislation also requires that coverage be extended to:[12]

1. "Essential spouses" who in December 1975 were eligible for Medicaid,
2. Persons who in December 1973 were eligible for Medicaid as inpatients or residents of medical institutions and who otherwise would have been eligible for cash assistance if not in such institutions, and
3. Persons eligible for public assistance in August 1972 and but for a 20 percent increase in the Social Security payment (OASDI) received in 1972 would be eligible for SSI in the current month.

Finally, the eligibility issue is further contorted by legislation requiring that the program include:

1. Persons who are eligible, but have not applied for SSI.
2. Persons in an SNF or ICF who are Medicaid eligible only in the facility. This coverage is optional and limited to individuals with incomes less than 300 percent of the SSI benefit level.

States that elect a standard for eligibility more restrictive than SSI do so under section 209B of the Social Security Amendment (209B states). For choosing this option, these states must allow SSI-related individuals to "spend down" to the more restrictive income or assets level. The concept of spend down is discussed later.

The considerable choice in program eligibility has led to considerable variation in coverage across the states. Some states have chosen the federal SSI definition for eligibility. Others have liberalized cash assistance benefits and extended Medicaid eligibility to more individuals. Finally, about twenty-five states have more restrictive requirements (209B states). These states are generally more concerned with the treatment of client assets than with income.

The medically needy are the second major eligibility group. These are persons who, while they do not qualify for Medicaid assistance, have incurred high medical expenses. Not all states

have this medical necessity option, though 209B states are required by law to offer it. In states that have elected the option, a close accounting of income and expenses is done to determine eligibility.

Each state that services the medically needy establishes a Medically Needy Protected Income level (MNPI). Persons become eligible for Medicaid if their income initially exceeds the MNPI level, but medical expenses that Medicaid would normally cover reduce the income below it.

The process by which this reduction occurs is called the "spend down." Both medically needy individuals and SSI recipients in 209B states must be allowed to spend down to eligibility. The actual spend down process is fairly complicated, requiring definitions of income and countable expenditures, sophisticated treatment of assets, and documentation of expenses.[13] To cite a simplistic example, consider an SSI recipient receiving $208/month in cash assistance in a 209B state. Since the state has set a MNPI below the SSI amount the client is allowed to spend down. Certain medical expenses are deductible from this income. With a one-time expense of $80 for covered services for one month, this person may spend down to $128 ($208 - $80) and probably be entitled for Medicaid.

Several factors complicate this description. As noted above, the treatment of income may vary from state to state. Additionally, the state's choice of an accounting period may affect eligibility. In the example above, we assumed a one month accounting period. However, since states enjoy considerable freedom in designating the period, the time over which expenses count could be as long as six months. In the example above, if the accounting period were four months instead of one, a one time $80 expenditure would not seem so difficult to handle. In that case the figure would be,

$$\frac{(208 \times 4) - (80 \times 1) \text{ or } 752}{4 \qquad\qquad 4} = \$188$$

The $188 with a six month accounting period differs considerably from the $128 figure with a one month period (or with an ongoing monthly expenditure of $80).[14]

Additionally, the requirement that medical expenses be carefully recorded and receipts kept places a large burden on the elderly individual. In this context, it is not surprising that most individuals using the spenddown provision reside in long term care facilities.*

*Of course this is also a function of the high cost of institutional care which forces people into the medical assistance program.

As is apparent, state variations in the Medicaid programs are wide. Eligibility is different across states and the MNPI levels differ markedly as well. As discussed below, the service universes in the states also differ widely.

The actual Medicaid eligibility process is handled on the local level. However, states differ in their relationship with the Federal government. In states serving only SSI recipients, eligibility data is routinely supplied by the Social Security Administration. In 209B states and in states serving the medically needy, eligibility criteria and procedures are determined and administered by the states.

The state and Federal government also collaborate in what is called the Medicare "Buy-in." In the Buy-in system, the state identifies medical assistance clients or applicants and with Federal help ascertains Medicare eligibility. Most of the work is done with an exchange of computer tapes, and the state pays the Part B premium. For most individuals these premium costs are eligible for federal cost sharing under the state's regular Medicaid match.

2. Services

There is a wide range of services permitted under the Medicaid legislation. They include:[15]

1. Physicians' services,
2. Inpatient hospital services,
3. Outpatient services (including rural health clinics),
4. SNF services for persons 21 and over,
5. Lab and x-ray services,
6. Family planning services,
7. Early and periodic screening, diagnosis, and treatment of physical and mental defects for children.

These seven services must be offered to the categorically needy. For states covering the medically needy, these seven may be offered, or instead, any seven of the remaining optional services. Included among the remaining services are dental care, therapies, drugs, intermediate care facilities, private duty nurses, eyeglasses, prostheses, and personal care services. Additionally, medical transportation must be provided and home health services must be provided for any individual entitled to SNF care.

Medicaid is an entitlement program. Persons are designated eligible to receive certain services. Such eligibility, however, does not guarantee receipt of services, for there may be no providers offering services. The supply of vendors frequently restricts actual service utilization. Thus, while an individual may be eligible for home health services, if there is no provider

in the area it is a vacant entitlement. Since the state has the right to set reimbursable limits for services, an inordinately low rate may be unattractive to vendors, thereby keeping the service scarce.[16]

Finally, the states also have discretion to limit the amount or duration of services. Physician visits may, for example, be limited to two per month. Inpatient hospital services may require prior authorization and be limited in much the same way that Medicare limits inpatient stays. In short, beyond the decision of what services will be covered in their plan, states also have the authority to restrict and limit utilization.

C. TITLE XX: SOCIAL SERVICES

In 1974, social service programs formerly under several titles of the Social Security Act were made into one single program, Title XX. Under the new title came considerable state discretion in the use of these funds. In 1975, Title XX was funded at $2.5 billion dollars. This figure was matched by approximately $833 million in additional state and local funds. In fiscal year 1979, the ceiling was $2.7 billion dollars.

Distribution of the grant is on the basis of population. The $2.5 billion represents about $11.60 per capita,[17] and the state share is 25 percent for most services. Title XX is a closed-ended grant program to the states, though states "earn" their grant through watching expenditures. In the first several years of the new Title XX program, many states were not able to document expenditures adequately enough to earn their full share. Currently, most states spend well over their ceiling, though they receive no more than their fixed allocation from the Federal government. Until recently, there was an open-ended provision for training in the legislation for FY 79; however, the fund was closed at $75 million.

As a form of grant, Title XX provides minimum Federal requirements for state's planning; accordingly, services, eligibility and program administration differ widely.

1. Eligibility

Eligibility under Title XX includes all recipients of AFDC and SSI. States may also provide services on an income-related basis to persons earning up to 115 percent of the state's median income. Fees are mandatory for all persons whose income exceeds 80 percent of the state's Medicare income. Only a few services are available to persons whose income is above 115 percent of this level. However, provisions are made in the regulations for group eligibility; these usually involve the inclusion of residents of specific geographic areas.

2. Services

Title XX services are directed at accomplishing five goals:

1) self-support;
2) self-sufficiency;
3) preventing or remedying neglect, abuse, or exploitation of children or adults and preserving families;
4) preventing inappropriate institutional care through community based programs, home-based care, or other forms of less intensive care; or
5) securing referrals or admission for institutional care.

The services available under the program are: [18]

Day Care (children and adults)
Substitute Care (children and adults)
Protective Services
Family Counseling
Home-Based Services
Employment, Education and Training
Health-Related Services
Information and Referral
Transportation
Day Services
Family Planning
Legal
Home Delivered and Congregate Meals
Other

Services for the elderly might include chore services, homemaker, congregate meals, home health services, home and money management, protective services, transportation, legal services, and respite care. However, the nature of the Title XX reporting systems does not allow us to easily identify services going to the elderly. Additionally, definitions of services vary by state.

The program regulations draw some important limits on room and board and on medical services. Briefly, neither service can be provided (with Federal financial participation) unless the service is an "integral but subordinate part" of a service described in the service plan. Additionally, the medical service must not be available in the state's Title XIX plan or through Medicare.

However, the attempt to separate medical from social services still leaves considerable overlap between social and health services under Titles XIX and XX.[19] Additionally, the federal regulations have developed what has become known as the "fifty-percent rule." This rule states that half of the state expenditures must be on behalf of (1) persons who are receiving (or are eligible to receive) AFDC or SSI, (2) persons whose needs or resources/income are taken into account in determining the latter's eligibility, or (3) persons who are eligible for medical assistance under Title XIX. The rule provides some possible earmarking of Title XX funds for the elderly.[20]

3. Program Administration

There are two ways that states administer the Title XX program. The state may only supervise; funds are frequently passed on to the counties, where actual service delivery is negotiated and overseen. Other states administer the program and deliver services themselves. Details of such operations are beyond the scope of this discussion. However, it is important to understand the Title XX planning process, where service priorities are determined.

Federal regulations provide that each state issue a Comprehensive Annual Service Plan (CASP). The CASP identified units of services to be delivered, recipient groups served, dollars to be spent, and toward which of the five goals the service will be directed. For an advocate of an elderly group to influence the CASP, that group must involve itself in the CASP development process.

The CASP process, however, varies in each state. States have several different budget years (calendar year, federal fiscal year, regular fiscal year) and planning is coordinated with each.[21] However, prior to its final submission, Federal regulations require that the proposed CASP be open to a 45 day comment and review period. Thus, the service decision process admits interest group participation in the initial planning stage and during the 45 day review period.

D. VETERANS ADMINISTRATION PROGRAMS

The Veterans Administration (VA) provides acute and long term care services to veterans of the armed services. The VA also has a substantial cash payment program for use in purchasing "aid and attendance" services.

The health care programs involve hospitals, nursing homes, and domiciliary facilities. In VA hospitals, medical bed patients, skilled nursing patients, and psychiatric patients are treated. Nursing and domiciliary care are provided at 18 facilities owned by the VA and under contract at many other facilities. Seventy percent of the 57,000 veterans in these facilities were over 60 years and fifty percent were over 70 years old.[22]

The Veterans Administration also provides a limited amount of hospital-based home care. Services provided include home health aides, home nursing, and transportation.

Monthly cash supplements are also available to veterans with service- and non-service connected disabilities. The supplement is designed to purchase "aid and attendance" service for veterans. The payment is made regardless of who performs the service, and since services are not monitored by the program, it is unclear whether these services are actually provided.

Eligibility is based on physician-certified disability. The cash amounts are modest, ranging from $49 per month to housebound veterans to $123 per month for bedridden veterans. If the disability is service connected, the figure may be considerably higher. All of these amounts are supplements to the regular military pension.[23]

E. TITLE III OF THE OLDER AMERICANS ACT

The Older Americans Act of 1965 was enacted to assist in the development of new or improved programs to meet the needs of persons over 60. It is administered at the Federal level by the Administration on Aging. At the state level, it is administered through a network of State and Area Agencies on Aging. The purpose of the act is to "secure and maintain maximum independence and dignity in a home environment for older persons capable of self-care with appropriate supportive services."2.1

Before October 1978, the Act contained separate titles for social services (Title III), senior centers (Title V), and nutrition services (Title VII). The 1978 amendments to the act consolidated these into Title III. There are presently appropriations for social services and meal services. Federal participation in the form of a matching cost share varies between 75-90 percent.

State Agencies develop and evaluate social service needs of the area. Area Agencies develop plans for coordination of services and negotiate to purchase services from local providers. In general, the Area Agencies cannot provide direct services, and many of the grants therefore go to community organizations.

1. Eligibility

Title III extends eligibility to all persons 60 and over. There is no income requirement, though individuals are often asked to contribute based on ability to pay. Detailed information is not available on the actual composition of the population receiving this service, though the services are required to be targeted for low income minority and isolated older persons.

2. Services

Twenty-three services are presently eligible for Title III funding. Additionally, the Administration on Aging has designated four services as national priority services--home services (homemaker, home delivered meals, home health aide), transportation, legal and counseling. All of these services must be provided in the state plan. Under the 1978 amendments, fifty percent of a state's appropriation must go to a mix of three service areas: "access services" (transportation and information and referral), in-home services, and legal services.

2.1 Butler, Patricia Financing Non-Institutional Long-Term Care Services, p. 37.

F. HOUSING PROGRAMS

Housing programs are not usually considered part of the long term care system. However, affordable and decent housing is clearly a prerequisite for the elderly to remain in the community. Inasmuch as all means tested programs (Title XIX) take special care in recognizing housing needs, these programs and their inter-relationship with social services need more attention from policy-makers.

The Department of Housing and Urban Development (HUD) does not provide services in the housing it funds. However, Section 231 of the Housing and Community Development Act provides Federal loans for rehabilitation and construction of elderly housing and allows that construction to include space for health or social services.[24]

Several of the HUD programs are highlighted below:

- Section 231 of the Housing and Community Development Act provides insured mortages to assist in the construction of new or the rehabilitation of rental housing for the elderly and handicapped.

- Congregate housing provides housing for the elderly and handicapped. Such housing need not have separate kitchen facilities for each unit. Funding is provided through several programs.

- Section 8 of the Housing and Community Development Act provides rent subsidies. The subsidies are for low income persons and are designed to insure that they pay no more than 25 percent of their income for housing.

- Section 202 provides direct loans to non-profit sponsors for housing for lower income persons who are elderly or disabled.

SECTION III

ISSUES RELATED TO THE CURRENT SYSTEM OF FINANCING LONG TERM CARE

There is a standard litany of problems and issues associated with the current long term care system. This list typically includes:

- The presence of an institutional and medical care bias in the flow of public funds for long term care;
- Heavy financial burdens placed upon individuals and their families;
- Both horizontal and vertical inequalities associated with major financing programs;
- Lack of community placement and delivery systems;
- An unclear and confusing array of intergovernmental roles in financing, administering, and delivering long term care services; and
- Lack of client choice in the types of care they receive.

Some of these problems are a direct result and some an indirect result of paritcular financing programs. However, several of these problems could also be categorized as delivery system issues and thus are a result of the complex system of financing.

The cross-cutting nature of these issues will be apparent throughout this discussion. The discussion begins with an examination of some of the issues that surround the long term care aspects of the Medicare and Medicaid programs. We then discuss issues that are not related directly to a particular program but rather are systemic in nature.

A. PROGRAM ISSUES: MEDICARE

1. Deductibles and Co-Payments in Covered Services

Although exact figures are not available, data suggest that even for covered services, Medicare recipients incur a significant liability as a result of the present system of co-payments and deductibles. A recent Urban Institute study estimates that co-payments and deductibles for covered Medicare services average approximately $300 per recipient.[1] It should be noted that this estimate does not include blood deductibles outside of the hospital, charges considered to be above the reasonable charges, or late fees for Part B premiums.*

2. Service Limitations and Program Administration in Covered Services

It is often argued that Medicare does not adequately address the long term care needs of chronically ill and disabled elderly.[2,3,4] An examination of the limitations on the use of skilled nursing facilities and home health care clearly illustrates Medicare's failure to meet long term care needs.

The fact that Medicare covers only up to 100 days of skilled nursing care per benefit period and that this benefit can only be used after a minimum of a three day stay in an acute care hospital suggests the acute care nature of the Medicare program. Similarly, home health care benefits under Part A are also tied to a hospital stay and are limited to 100 days per benefit period. Although home health care benefits under Part B are not tied to a hospital stay, they are also limited to 100 days per episode of illness. Indeed, the fact that Medicare regulations use language such as "episode" is very suggestive of the program's acute care bent.

Not only do the limitations placed upon these services prevent them from adequately addressing the long term care needs of the elderly, but statutory limitations on the target population, nature of services, and restrictive conditions of participation for home health care agencies further limit their usefulness in meeting these needs.[5,6] Home care services are, for the most part, restricted to skilled services provided on an intermittent bases. Furthermore, home health services are not authorized for persons with medically stable conditions or for individuals who are not housebound. Therefore, an individual who only requires homemaking services will not be eligible for home care benefits under Medicare. It also appears that "intermittent" has been interpreted to mean a few hours per day, several times a week. According to a Congressional Budget Office report, "for home health aide visits, claims exceeding 20 hours a week are usually denied."[7] On the other end of the spectrum, the regulations prohibit one-time or "nonpredictable" care. Thus, home care benefits cannot be used to reduce the pressures placed on informal caregivers.

Not only are the home care benefits provided by Medicare restrictive, but the conditions of participation for home health agencies have probably restricted the availability of home health services. According to these conditions, proprietary agencies

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*Although Medicaid pays for part B expenses for some elderly under the buy-in agreement, it is estimated that only about 15% of Elderly Medicare recipients were included in buy-in agreements in 1975 (Davidson, Marmor, 1980).

must meet state licensing requirements in order to participate in the Medicare program. However, only twenty-one states have such laws. In other words, in all but twenty-one states, proprietary agencies are barred from participating in Medicare's home care program. The conditions of participation also require that the agency provide at least two skilled services. It has been estimated that this provision has eliminated 500-700 rural visiting nurse associations from providing care in underserved areas.[8]

3. Services Not Covered:

In addition to the limitations and restrictions on covered services discussed above, many, if not most, services that are normally considered long term care services are simply not covered under the Medicare program. Long term care services typically include:

- Nutrition services (including meal preparation)
- Homemaking
- Chore services
- Legal services
- Transportation
- Personal care
- Health related therapies
- Skilled nursing
- Physicians' services
- Medications
- Specialized housing
- Dental care
- Visual and auditory services and devices

Since Medicare has developed as an acute medical care program, many of these services are not included in either the Part A or Part B benefit packages.

The uncovered services that have had the most direct financial impact on the elderly are the lack of coverage of intermediate care facility services and outpatient drugs.[9] The direct financial implications of the lack of benefits for such things as dental care, routine foot care, eyeglasses, hearing aids, homemaker, and chore service are probably not as great, but their possible impact on recipient function and rate of institutionalization remain key policy questions.

The basic conclusion that should be drawn from this discussion is that Medicare, as it is currently structured and administered, cannot be considered a major source of funding for long term care services for the elderly. Its strict limits on skilled nursing home care, its complete lack of intermediate and its lack of benefits that relate to functional rather than medical needs, suggest that the elderly must look elsewhere for financial protection against expenditures associated with chronic illness and functional disabilities.

B. PROGRAM ISSUES: MEDICAID

As indicated by the figures presented in the tables and program descriptions later in this section, Medicaid is clearly a major source of public payment for long term care services provided to the elderly. This is particularly true for institutional care. Aside from the systemic issue of people having to be poor or near poor to participate in the program (which will be discussed in the next section), the structure and administration of the Medicaid program creates several programmatic issues. Among the more important of these are an institutional bias in the use of funds, the inequities that arise from state variations in eligibility, state variations in benefits, state variations in the use of the Medicare buy-in provision, and possible restricted access to institutional care due to low reimbursement rates. Each of these issues will be briefly discussed.

States vary considerably in their coverage of the medically needy and in those not automatically eligible for Medicaid because of income maintenance status. Under the provisions of the legislation, states exercise a choice in the setting of income and cost criteria. The choices available include covering only SSI recipients, covering those who receive SSI and a supplement, or extending coverage to individuals below the SSI income levels. In the latter case, a spend-down must be available to clients and the medically needy must be included. The spend-down for the medically needy is optional in states choosing the first two eligibility options. Thus, considerable horizontal inequities were present in the system from the start.

In states that do use a spend-down, additional variations exist in eligible income levels. Again, since the states can set their own qualifying income levels, persons with the same income in different states are often treated differently.

Furthermore, according to Davidson and Marmor,[10] "the spend-down device is not available to meet the non-institutional Medicaid expenses of the elderly who reside in sixteen states where Medicaid eligibility is automatic with SSI and where there are no medically needy programs."

This not only leads to horizontal inequities across states, but also to horizontal inequities within states across localities. Furthermore, the provision is but one of several examples of the institutional bias associated with the long term care provisions of the program.

States can, at their discretion, pay the premiums of Medicare Part B and the co-payments under Part A for those elderly who are eligible for both Medicare and Medicaid. This "buy-in" agreement not only makes the benefits package of both programs available to

the recipient, but it also permits recipients to purchase their medical services outside of the Medicaid-welfare system. However, not all jurisdictions participate or fully participate in the buy-in program. Although forty-five states and the District of Columbia provide buy-in coverage for their categorically eligible elderly, only thirteen of the twenty-nine states that have medically needy programs buy-in those that qualify as Medically needy. This causes additional horizontal inequities across plans.

Besides having considerable control over eligibility criteria, states also have great flexibility with regard to optional services and the duration and scope of each service benefit. For example, fifteen plans don't cover podiatric care, fifteen plans offer podiatric care to only the categorically needy, and twenty-four plans offer the service to both the categorically and medically needy. Table 1 presents a summary of plan variations in those optional services that are most likely to be used by the chronically ill and functionally disabled elderly.

Table 1

Summary of State Variations in Optimal Medicaid Services

(1975)

Services	States Not Covered	States Covering Categorically Needy Only	States Covering Both Categorically & Medically Needy
Optometrist	12	18	24
Podiatrist	15	15	24
Dental	9	16	29
Physical Therapy	18	12	24
Eyeglasses	13	15	26
Prescription Drugs	4	21	29
ICF	5	24	25

Source: Adapted from Table 3-3, Davidson, Stephen M. and Marmor, Theodore, The Cost of Living Longer. Lexington Books, 1980.

Thus, persons in the same health and financial situation could be eligible for vastly different services depending upon where they live. In addition, there is a certain amount of variability across states in the duration and scope of each benefit.

In statute, home care benefits under Medicaid are, in general, more liberal than under Medicare. Under Medicaid, home care benefits are not tied to a hospital stay, personal care services for medically stable individuals are possible, and the individual need not be housebound. However, Medicaid expenditures for home care have remained very small. In fact, many states, fearing potentially high demand for these services, have developed very restrictive programs. "In an effort to control the rising costs of Medicaid, at least fifteen states have adopted the Medicare restriction. Other states have established reimbursement rates that are significantly lower than Medicare rates."[11] Thus, the long term care aspects of most state Medicaid programs remain primarily institutional.

Even with this bias toward institutional care, there is mounting evidence that low Medicaid reimbursement rates for nursing home care is resulting in problems of access to care for Medicaid recipients. This is particularly true for patients who are very disabled and require heavy care.[12,13]

To summarize, although Medicaid is a principal source of payment for long term care for the elderly, it currently provides mainly institutional care. Furthermore, there are a great many inequities in the program that are a direct result of variations in eligibility and benefits across plans. Finally, there is mounting evidence that access to institutional care for Medicaid recipients is becoming more difficult as a result of low reimbursement rates.

C. SYSTEMIC PROBLEMS

An examination of the problems associated with individual funding sources, while instructive, does not capture some of the most serious and difficult problems related to the total system of financing long term care. It is the degree to which programs articulate that, to a large extent, determines the nature of the delivery system. Indeed, it is often argued that the lack of a "systems" approach to long term care led to the problems of overuse of institutional services, forced poverty, lack of community alternatives, and the dominance of the acute care medical model.

As we have seen, Medicaid pays for a very large proportion of the institutional long term care of the poor. Unfortunately, Medicare has a very limited institutional benefit. With the exception of the Veterans Administration, there are no other significant

non-means tested sources of public funds for institutional long term care for the elderly. Furthermore, the private market for long term care insurance is virtually nonexistant. Bishop argues that due to low demand (caused by the discrepancy between income and necessary premiums over the life cycle), adverse selection, moral hazard, administrative diseconomies, and uncertainties of expected payment (due to inflation), it is unlikely that private insurance for long term care will develop. This lack of public insurance or benefits, coupled with the lack of private insurance, results in a huge financial burden for individuals and families of individuals who require long term care services. It is estimated that, in 1975, over fifty percent of all long term care was paid out-of-pocket by patients and their families.[14] This enormous financial burden impoverishes thousands of elderly persons each year. According to the Congressional Budget Office, "47.5 percent of nursing home patients whose costs were paid by Medicaid in 1974 were not initially poor by state definitions, but depleted their resources and qualified as medically needy."[15] The financial burden placed on the elderly and their families is clearly one of the most important issues confronting the long term care system.

Another important systemic problem has to do with the direct and indirect bias towards institutional care caused by the current financing system. The fact that most long term care benefits paid for by Medicare and Medicaid are for institutional care would not be a problem if there existed other plentiful and easily obtainable sources of community-based care. This is clearly not the case. The total amount of public funds that go towards community-and home-based care represents only about ten percent of the total long term care expenditures. Furthermore, funding for community- and home-based social services comes mainly from closed-end financing programs such as Title XX, Title III, and various state and local programs. This has resulted in most long term care services being medical in nature even though many long term care care needs are in the area of social services.

In addition, the fragmented nature of funding for community long term care makes it particularly difficult to develop and implement a comprehensive program of care. It is not unlikely that an individual might need nursing service from a visiting nurse association, homemaking services from a Title XX agency, meals on wheels from a Title III program, and specialized housing. Each program or source of funding has its own set of rules and regulations, eligibility criteria, and kinds and quantity of services available. Furthermore, no one agency is formally responsible for the coordination and supervision of all of these various services. It often becomes the responsibility of clients or their family to perform this care management function. In contrast, when a person enters a nursing home, all of these needs become the responsibility of the facility. It is therefore much easier, if not always appropriate, to place an individual in an institution.

Finally, it is important to note that the fragmented nature of funding has also made it extremely difficult to reform the system. To do so successfully would require an understanding of all relevent programs (in three Federal Departments), their interrelatonships, inconsistencies and gaps. As it was put in a recent research proposal, "there is no one locus for change, but a series of points of interaction that crisscross agency levels of government, the public and the private sectors."[16]

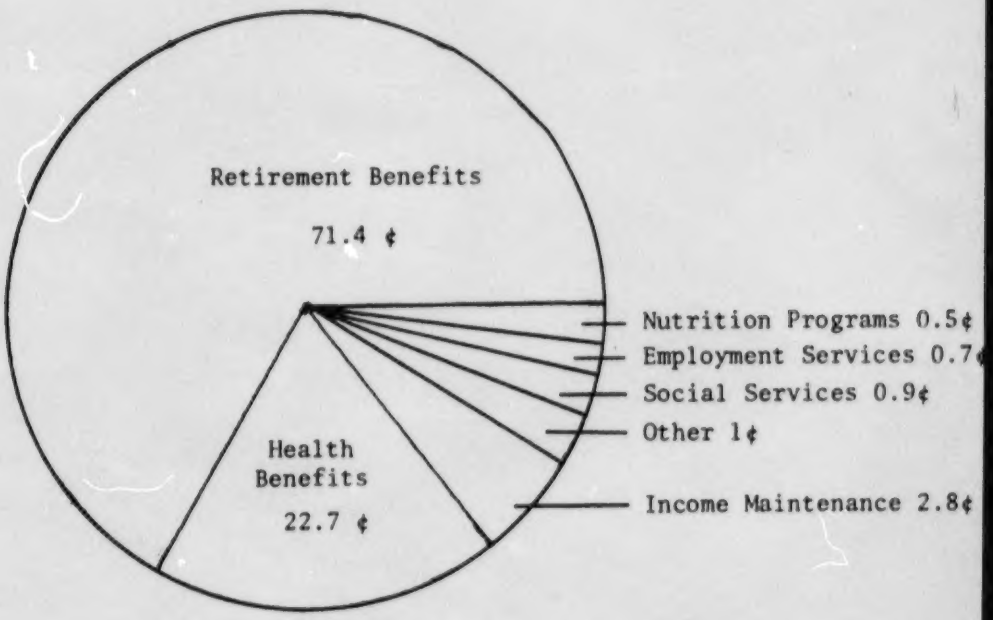
The rest of this section discusses funding under Titles XVIII, XIX, XX, and Title III. It is the intent of this discussion to show how the inequities and biases of the current system of longterm care translate into actual expenditure levels. An attempt is also make to put spending under these titles in the context of other federal health and social service programs.

D. TOTAL FEDERAL EXPENDITURES

The House Select Committee on Aging has identified forty-eight Federal programs which affect the aging populations.[1] This report documents a 139 billion dollar Federal expenditure for all senior services and programs. This figure includes social services, retirement benefits, health services, and several other areas. The total expenditures are expressed below as fractions of the total federal senior dollar.[2]

Figure 1

The Federal Senior Benefit Dollar



Source: Select Committee On Aging (Publication No. 96-276) May, 1980, p. 31.

It is, however, important to look at actual figures. Table 2 shows estimated Federal benefits in select programs for the elderly:[19]

Table 2

Estimated Federal Benefits For The Aged - 1980

(Billions of Dollars)

Social Security (OASI)	79.7
Social Security (Survivors)	12.6
SSI	1.7
Veterans' Pensions	2.4
Medicare[a]	27.6
Medicaid[b]	5.1
Food Stamps	0.5
Subsidized Housing	1.7
Other Programs	0.8
	$132.2

This figure represents about one-fourth of the Federal budget of $531.6 billion. However, leaving out social security retirement, which is a deficit spending program, reduces this phase to 9.9 percent of the total federal budget.[20]

1. Medicare and Medicaid

Figures from the Medicare and Medicaid Programs are instructive in estimating institutional versus non-institutional costs. Current Medicare figures from the Fiscal Year 1981 Budget are shown below:[21]

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a. Adjusted to reflect FY81 Federal Budget estimates
b. Adjusted to reflect FY81 Federal Budget estimates and a 38 percent elderly share.

Table 3

Medicare Expenditures for the Aged FY1980 - Estimated

(Thousands of Dollars)

Part A - Hospital Insurance	
Total	19,600,000
SNF Care	365,000
Home Health	492,000
Part B - Supplemental Medical Insurance	
Total	8,025,000
Physicians	5,940,000
Home Health	197,000

Total, Parts A & B = 27,625,000

These figures show that $689 million dollars is going to home health services under Medicare programs. This is equal to about 2.5 percent of total expenditures in the program. There seems to be a clear acute care bias in Medicare. Medicare is clearly an acute care program with little capacity to meet the extended longterm care needs of the elderly.

Data on Medicaid expenditures are reported by the states and generally in a less accessible form that requires some manipulation. Nevertheless, the clear institutional bias of such expenditures is apparent.

Medical assistance costs are expected to total $25.3 billion dollars for FY 1980. Subtracting administrative costs, the total costs, the total cost is 24 billion dollars in FY 1980. This is expected to rise to 26.2 billion in FY 1981. In 1979, the program served 22,894,000 persons, of whom 3,690,000 (or 16.1 percent) were age 65 and over.

Data from the Medicaid Management Institute (1979) suggests that 38 percent of the total Medicaid expenditures in 1976 were for services to the elderly.[22] Using this figure, the FY 1980 Medicaid is estimated at 9.12 billion dollars. Using expenditure data from the same source, this figure can be broken into the following service areas:

Table 4

Percent Total Medicaid Expenditures by Category of Care

(1976)

Inpatient Care	11.1%
Skilled Nursing	32.2
Intermediate Care	39.7
Physicians	3.8
Dental	0.7
Prescription Drugs	8.9
Other Services	3.6

It is clear that the majority of Medicaid expenditures go to skilled and intermediate care facilities (71.9 percent). This is roughly 3.8 billion dollars annually (including both Federal and non-Federal shares).

The exact expenditures for non-institutional home health and personal care services are estimated at 179 million dollars or one percent of the total Medicaid expenditures.[23] We assume that most of this is spent on the elderly. On the basis of these figures, we can make the following estimates of expenditures by service type for the Medicaid program:

Table 5

Medicaid Expenditure by Type of Service

Estimated FY 1980 - (Thousands of Dollars)

Inpatient Care	1,013,000
Institutional Care	6,557,000
Physicians' Services	347,000
Other Services	1,024,000
Home Health	179,000
Total	9,120,000

On the basis of this analysis it is clear that both Medicare or Medicaid, under present program priorities, are heavily biased towards institutional and acute care treatment of the estimated total $36.7 billion spent on both programs about two and one-half percent goes to home health programs. As alternatives to institutionalization, these programs are clearly accorded second-rate status.

2. Title XX and Title III Programs

Title XX provides social services to several age groups and types of clients. Utilization and cost data reported by the program is notoriously unreliable; however, some estimate of services to the elderly can be made. Several Title XX services to the elderly qualify as services which prevent or delay institutionalization. These include chore services, homemaker, home health aides, home management (including money management), legal services, adult day care, and meals programs. Butler quotes an DHEW figure that estimates 481 million dollars was spent nationally on the first four of these services under provisions of the act.[24]

Title III of the Older Americans Act provides many services for the elderly delivered through Area Agencies on Aging. Considerable effort also goes into coordination of services and administrative service development. Total dollars going for direct service activities in FY 1978 were $93,681,000 for services and 294,459,000 for nutrition and meals programs.[25] The total of $388,140,000 does not distinguish type of services,[26] though all are social services and have no medical or residential components. There is little good data on the actual distribution of service costs, so it is assumed here that all are long term care related services. Additionally, this figure is somewhat understated since a non-Federal cost share is required. Data on the non-Federal share are not included here.

Thus, funds available for longterm care related services were $481,000,000 under Title XX and 388,140,000 under Title III for a total of $869.1 million.

3. Summary

This discussion has used data from several sources to investigate funding in four major health and social service areas. While the data presented are not strictly comparable and are occassionally from different reporting periods, a comparison of the various programs is useful. In particular, the expenditures for non-institutional long term care provisions of these programs are shown below and compared to total program expenditures on the elderly.

Table 6

Long Term Care Related Service Expenditures in Four Programs - Estimates

(Thousands of Dollars)

Program	Non-Institutional Long Term Care Expenditures	Total Elderly Expenditures
Medicare	689,000	27,625,000[a]
Medicaid	179,000	9,120,000
Title XX	481,000	481,000[b]
Title III	388,140	388,140
Total	1,737,140	37,614,140

Table 6 shows that only 4.6 percent of all expenditures go to non-institution based long term care. Medicaid expenditures for nursing home care alone are almost four times greater than all non-institutional long term care. Removing an estimated $19.6 billion of Part A inpatient hospital costs from the total expenditure column still leaves the non-institutional care at less than ten percent of the total.

While these figures may be slightly low estimates, a picture of poor funding for non-institutional based long term care services emerges. The services available are predominantly welfare related (means-tested) and Medicaid related. Remembering that Title XVIII and XIX are open-ended and Titles XX and III are closed-ended one can expect these differences and biases to become even greater in the future.

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a. Includes inpatient hospital costs (Part A)
b. Actual figure is unknown.

SECTION IV

RECENT PROPOSALS TO DEVELOP ALTERNATIVE FINANCING STRATEGIES FOR LONG-TERM CARE SERVICES

This section focuses on recent recommendations and legislative proposals which attempt to address some of the recurring problems in the long term care system that were discussed in the preceding section. By design, we have omitted the many long term care demonstration efforts that have been conducted by the National Center for Health Services Research, the Health Care Financing Administration, and the Administration on Aging. The reader interested in obtaining more information about these demonstration efforts is referred to Greenberg et al., 1980. Instead, we focus our attention on proposals that have been introduced in the last several years that are designed to alter existing long term care financing programs.

Like most attempts at health and welfare reform, these proposals range from simple tinkering with existing programs to the development of radically new organizational structures and funding streams. At the risk of oversimplifying, we divide these proposals into five general strategies. They are:

- incremental adjustments to existing programs;
- long term care insurance for the elderly;
- single-entry community-based care systems: closed-ended financing;
- single-entry community-based care systems: open-ended financing; and
- social health maintenance organizations.

In addition, we briefly review the long term care components of three National Health Insurance proposals. The remainder of this section is devoted to a discussion of these options.

A. INCREMENTAL ADJUSTMENTS TO EXISTING PROGRAMS

"Option A" presented in the Congressional Budget Office (CBO) Report on Long Term Care for the Elderly and Disabled, clearly falls under the category of incremental program change.[1] CBO Option A would modify existing programs by eliminating the Medicare homebound requirement for home health services and expanding the definition of skilled nursing services to include nutritionist services (but not meals programs) and occupational therapy. Homemaker services would be permitted after skilled services were no longer required. The conditions of participation would be changed for home health agencies to permit participation of agencies that only provide one skilled service and to remove the licensing requirement for proprietary agencies. Under Medicaid, home health services would be expanded and the mandatory services would be expanded to include more basic support services.

This option does not change eligibility requirements, and issues of utilization and cost-containment are not addressed. However, a variation of this alternative - "Medicare Part C" - is also suggested to expand home health services by eliminating the three day prior hospitalization requirement.[2]

In a recent report entitled Home Health and Other In Home Services: Titles XVIII, XIX, XX, of the Social Security Act. DHEW recommended several changes to existing programs. These changes included:

- removal of the three day prior institutionalization requirement under Medicare;
- establishment of minimum standards for reimbursement for home health benefits under Medicaid;
- extension of Medicaid categorical eligibility to additional aged, blind, and disabled groups;
- permitting care plan approval by physicians' assistants and nurse practitioners;
- upgrading training for homemaker/home health aides under both Medicare and Medicaid; and
- initiating coordinated planning at all levels of government for these programs.

B. LONG TERM CARE INSURANCE FOR THE ELDERLY

CBO Option B and the Conable Bill are both examples of a public insurance approach to financing long term care.[4] Under CBO Option B, long term care insurance would be provided through a new entitlement program for all elderly and disabled persons. Eligibility for benefits would be determined through long term care centers which would certify disability levels. The program would be financed by Federal funds with some co-payment. A full range of services would be available.

The Medicare Long-Term Care Certificate of 1979 (HR58), known as the Conable Bill, would establish a new long term care trust fund under Title XVIII of the Social Security Act. The program develops a long term care center administrative structure. Local long term care agencies would arrange services, evaluate and certify individual needs, and evaluate providers.

The program would be financed with ninety percent federal participation and enrollees would pay a $3 per month premium. Services provided would include day care, foster home. homemaker, nutrition, personal care, and nursing home services.[5]

The reader who is interested in a public insurance approach to long term care is urged to read "A Compulsory National Long-Term Care Insurance Program" by Christine Bishop.[6] In this paper, the author develops the conceptual framework for treating disability-related long term care expenses as a problem amenable to social (public) insurance. The paper also discusses several issues that must be resolved before this approach can be put into practice.

C. SINGLE ENTRY COMMUNITY BASED CARE SYSTEMS - CLOSE-ENDED FINANCING (LONG-TERM CARE BLOC-GRANTS)

CBO Option C is an example of a closed-ended financing approach to the development of single-entry community-based care systems.[7] Under this approach, Medicaid and Title XX long term care funds would be consolidated into a comprehensive long term care grant to states. The grant would be closed-ended and would involve a state match. Federal funds would be "channelled" through community long term care centers. These centers would identify and assess clients, determine eligibility, certify providers, and monitor care provided.

The obvious advantage to this approach to financing long term care is that the Federal liability for expenditures is predetermined. However, in a recent political analysis of the long term care bloc grant proposal, Hudson concludes that this type of program may be fraught with problems:

> A bloc grant's working in accordance with the underlying programmatic intent rests on a number of assumptions about the incentives and agendas of involved parties, the structure or setting in which those agendas are played out, and the particulars of the policy area itself. In the case of long term care, there is good reason to suspect that several of the requisite assumptions cannot be made or relied on.[8]

Single-Entry Community Base Care Systems - Open-Ended Financing (Entitlement Programs)

Recent bills introduced by Representatives Fraser, Pepper and Waxman, and Packwood are all examples of an entitlement approach to developing single-entry community-based care systems.

The Older American Home Services and Catastrophic Insurance Act was introduced in the second session of the 94th Congress on June 18, 1976 by Rep. Donald Fraser of Minnesota.[9] The legislation provides for the establishment of new community-based care centers which would identify need, develop provider contracts, and coordinate services to clients. The service model would provide the usual compliment of in-home services. State participation is voluntary. The states would be eligible for grants covering up to seventy-five prcent of the cost of the program.

Title II of the same legislation develops catastrophic coverage under Medicare. The limits on inpatient services would be removed,though the deductibles and coinsurance would remain unchanged. Ceilings would be placed on total deductible and co-insurance for hospital stays and physician services. Other Part B services are not addressed in the legislation.

The Medicaid Community Care Act of 1980 (HR 6194), introduced by Reps. Pepper and Waxman, would amend Medicaid to allow for Federal financial participation in expanded community-based services and client assessment.[10] Under the provisions of this legislation, the current state Medicaid authorities would develop community care plans. These plans would develop a comprehensive assessment strategy for elderly persons seeking access to long term care services. The assessment team, after assessing the probability of institutionalization, would recommend some combination of the following long term care services: home health aide services, medical supplies and equipment, therapies, adult day care health services, respite care, homemaker services, and nutrition counseling. The legislation also allows for increased Federal financial participation in the cost of these services at a rate 25 percent above the existing federal match.

Title XXI - Comprehensive Community-Based Non-Institutional Long-Term Care Services for The Elderly and Disabled, to be introduced by Senator Packwood, would be, at least initially, a three-year demonstration grant. The grant would combine under one title (Title XXI) non-institutional long-term care services now provided for under Titles XVIII, XIX, and XX.[11] Eligibility would include all those sixty-five and over as well as the disabled. Services available would include: skilled nursing, therapies, social services, home health services, adult day care, respite care, and client assessment and screening.

The program would also embody a coordinating mechanism at the state level. The coordinating agency would supervise Preadmission Screening Teams which are responsible for assessing clients, developing care plans, arranging services, and evaluating progress.

D. SOCIAL/HEALTH MAINTENANCE ORGANIZATIONS

In many ways, the concept of a social health maintenance organizaton is similar to the proposals discussed under the heading "single-entry community-based care systems - open-ended funded." However, there are a few very important elements in the S/HMO concept that warrant separate discussion. In particular, S/HMOs would be paid on a capitation basis and would be responsible for the delivery of both acute and long term care.

The basic concept of the S/HMO is to expand HMOs' scope of coverage to include long term health and social services. The proponents of this concept argue that the combination of prepayment and the centralization of responsibility for acute care and long term care will lead to a more coordinated and comprehensive services package; to incentives that will discourage institutional care and encourage community- and home-based care; and to net savings in the system due to the substitution of appropriate but less expensive, treatment strategies.[12]

In addition, it would appear that the bills calling for single-entry systems envision a quasi-public agency which would be responsible for a particular catchment area. In contrast, the S/HMO concept would call for competition for enrollees in locations where population size would permit it.

E. LONG TERM CARE PROVISIONS UNDER VARIOUS NATIONAL HEALTH INSURANCE PROPOSALS

In this section, we briefly review the long term care provisions of three National Health Insurance proposals.[13] The three proposals that will be discussed are "The Comprehensive Health Insurance Plan" (CHIP), "The Health Security Plan," and the "Catastrophic Health Insurance and Medical Assistance Reform Plan." Readers that are interested in a more comprehensive discussion of the likely impacts that various national health insurance proposals will have on the availability of health services for the elderly are referred to a recent book by Davidson and Marmor entitled, The Cost of Living Longer: National Health Insurance and The Elderly.

The Comprehensive Health Insurance Plan (CHIP) was proposed by the Nixon-Ford administrations. It calls for a three-pronged approach which consists of (1) private insurance offered to employees by their employers, (2) state-operated program for low income families and families who are high risks, and (3) an expanded version of Medicare for the elderly. All three programs would have the same benefit structure. The long term care benefits under this program are rather restrictive. There are no ICF benefits and the SNF benefits are limited to 100 days per year. Home health services are limited to 100 days per year and would use current Medicare standards. Eyeglasses and hearing aids are not covered for persons over 13 years of age. Dental care is not covered. Co-payments and deductibles are a function of income.

The Catastrophic Health Insurance and Medical Assistance Reform Plan, introduced by Senators Long and Ribicoff, would provide a catastrophic illness insurance program for the general population and a federal medical assistance program for the poor and medically indigent. Although not discussed in the bill, it would appear that Medicare would continue.[14] The catastrophic illness portion would limit SNF care to 100 days per year and

does not include ICF care. Home care benefits are similar to the current Medicare program. Benefits under the medical assistance plan would include SNF and ICF care with no limits. No mention is made of home health benefits under the medical assistance plan. Again, personal care, dental, eyeglasses and hearing aids are not covered.

The Health Security Plan, introduced by Senator Kennedy and Congressman Corman, establishes a single Federally administered program that would cover the entire population. It would abolish Medicare and the federal share of Medicaid for covered services. The benefit structure includes SNF care but sets a 120 day per year maximum and does not include ICF care. Home care would be expanded to include personal and social services. It includes eyeglasses and hearing aids and would eventually include dental services for the elderly. It also covers prescription drugs needed for "chronic illness."

While each of these proposals make signficant changes in acute care programs and benefits, it is clear that none of them make anything more than incremental changes in either long term care benefits or the organization of the long term care sector.[15] It would appear that the framers of these proposals are not prepared to fully address the issue of long term care. An important and unresolved issue is whether long term care should even be part of National Health Insurance or whether separate long term care legislation is required. Joe and Meltzer suggest that

> Including long-term care as a benefit in NHI would do nothing, however, to address the problems of domiciliary care, VA services, Title XX services, or mental health care and would maintain the arbitrary classifications of institutions that now exist and the arbitrary division between health and non-health long-term care services without regard to actual client needs or service provision. Long-term care services include medical services but go far beyond even a broad definition of health care. Much of it is purely custodial care and a signficant portion is social and other rehabilitative services. To lump them all as medical/health services and try to include them in an NHI proposal is not only extremely expensive, but would further the tendency to keep long-term care within a rather limited medical model.
>
> From a public policy standpoint, recognizing both individual human needs and questions of the appropriate use of the health dollar, it does not make sense to support the inclusion of long-term care services in NHI. Realistically, however, unless an alternative strategy for financing long-term care services is developed, it would be impossible

> to reject its inclusion in NHI since there is the clear need to at least continue, if not expand, the revenues now available for existing health-related facilities and to move the funding to the Federal level with its more progressive tax base. What is needed as a companion to any NHI plan is a separate long-term care financing package that is tied to NHI in terms of the provision of medical services, but is not tied to any given institutional settings. An NHI plan or any other health financing plan should insure that medical care is available regardless of the setting (i.e., in an individual's own home, a foster care home, or an institution) and is not tied to the institutional definition, but to the health care needs of the individual.[16]

In closing, it is important to note that even the most comprehensive long term proposals are silent with regard to the special housing needs of the non-institutionalized chronically ill and functionally impaired elderly. While it may not be possible, or even advisable, to include housing as part of a long term care benefit package, the interrelationships between long term care programs and housing programs must at a minimum be carefully worked out. This calls for greater cooperaton and coordination among various Federal, state, and local agencies. Housing is a very important and quite often missing part of the continuum of care.

V. SOURCES OF FUNDING FOR DEMONSTRATION PROJECTS

As each Long Term Care Gerontology Center becomes operational, it will most likely become directly or indirectly involved in projects designed to demonstrate new and better ways to deliver long term care services. The key question at that point is usually "where can we get the money?" Besides the demonstration funds available under Title III of the Older Americans Act (which it is assumed that the centers have information about), there are three interrelated demonstration programs administered by the Health Care Financing Administration which will be of particular interest to the centers. In the section that follows we briefly describe each of these programs. In addition, we list several documents and organizations that centers may find useful in their quest for additional demonstration and research money.

A. SECTION 1110 FUNDS

The Department of Health and Human Services, Health Care Financing Administration, is authorized under Title XI, section 1110 of the Social Security Act to award grants for research and demonstration projects which pertain to the financing of health care and the provision and quality of health care services. These grants may be awarded to non-profit organizations and institutions, state and local governments and their agencies.

In 1980, long term care was designated as one of HCFA's ten priority areas. HCFA is interested in demonstrations that "plan to test new ways to pay providers of services in order to promote cost-effectiveness while providing appropriate care, and the development of added services in areas of identified need." (P19-HCFA Grants for Research and Development 1980).

Awards range from around $25,000 to $1,000,000 with most grants falling in the $25,000 to $250,000 dollar range (annually). Project durations of one to three years are the norm, but they may occasionally last up to 5 years.

Applicants for Section 1110 funds should use Form HCFA-PG-10. It is important to note that although HCFA Research and Demonstration Grant programs are not covered programs under OMB Circular A-95, some states have extended the project notification and review procedures required by Circular A-95 to assistance programs not covered under the Circular. Applicants should check with their state Clearinghouse as to the status of your particular state.

If you are not familiar with circular A-95, you will want to get a copy of the following bulletin:

Circular A-95: What It Is, How It Works
Office of Management and Budget
Executive Office Building
Washington, D.C. 20503

Application forms and information packets for all three HCFA programs can be obtained from:

Project Grants Branch
Office of Management and Budget
Health Care Financing Administration
Area E-1 Gwynn Oak Building
1710 Gwynn Oak Avenue
Baltimore, MD 21207

Telephone: (301) 594-3332

B. SECTION 1115 FUNDS ("MEDICAID WAIVERS")

Title XI, section 1115 of the Social Security Act makes special provision for grants to the state agency that administers the Medicaid programs. It allows for the waiver of elements of the state's Medicaid plan for the purposes of demonstration projects that will further the general objectives of the Medicaid program. Section 1115 allows for payment for services that would otherwise not be allowed under the Medicaid program, permits services to be delivered in designated geographic areas, and permits the waiver of a variety of the eligibility requirements specified in the state plan.

It is important to note that waiver requests must define the waivers which are required, state the specific waiver language, discuss the impact of the waivers on program expenditures, and indicate the effect on Federal, State and local laws. ONLY THE STATE MEDICAID AGENCY MAY BE THE GRANTEE. States may apply for "waivers only" or they may apply for both Section 1110 and 1115 funding. Applicants should use HCFA form PA 11 when applying for Section 1115 waiver funds.

C. SECTION 222 FUNDS

Section 222 (a) of the Social Security Amendments of 1972 permits the Secretary of HEW (now HHS) to waive usual Medicare coverage regulations for purposes of evaluating a variety of cost-saving approaches to health care financing and delivery.

The application procedure is similar to that discussed under Section 1115, except that the applicant need not be the state Medicaid agency and the applicant is to use Form PG 10. The National Day Care-homemaker experiments, as well as the Triage Program in Connecticut, were funded under this provision. However, informal conversations with HCFA personnel seem to indicate that the Department is reluctant to use Section 222 funds for service expansion projects.

D. OTHER RESOURCES

There is a great deal of written material available that deals specifically with how to obtain funds to develop programs and services for the elderly. Listed below are several references that the Centers may find useful.

1. Making Title XX Work: A Guide to Funding Social Services for People

   Order from: The National Council on the Aging
   1828 L Street, N.W.
   Suite 501
   Washington, D.C. 20036

2. Revenue Sharing and the Elderly: How to Play and Win

   Order from: The National Council on the Aging
   1828 L Street, N.W.
   Suite 501
   Washington, D.C. 20036

3. Planning Handbook: Transportation Services for the Elderly

   Order from: Publications Department
   Administration on Aging
   330 Independence Avenue, S.W.
   Washington, D.C. 20201

4. Planning Housing and Services for the Elderly

   Order from: American Association of Homes for the Aging
   1050 17th Street, N.W.
   Suite 770
   Washington, D.C. 20036

5. Planning and Financing Facilities for the Elderly

   Order from: American Association of Homes for the Aging
   1050 17th Street, N.W.
   Suite 770
   Washington, D.C. 20036

6. Foundation Directory, Edition 6

   Order from: Columbia University Press
   136 S. Broadway
   Irvington, NY 10533

7. The Foundation Center National Data Book, Volume One and Volume Two

   Order from: Foundation Center
   888 Seventh Avenue
   New York, NY 10019

In addition to written materials, there are a number of national organizations that either provide support for research and demonstrations or might know of the availability of such support. The names and addresses of several of these organizations are listed below:

1. National Council on Aging

   Address: NCOA
   1828 L Street, N.W.
   Suite 501
   Washington, D.C. 20036

2. National Council on Senior Citizens

   Address: NCSC
   1511 K Street, N.W.
   Washington, D.C. 20005

3. American Association of Retired Persons/National Retired Teachers Association

   Address: AARP/NRTA
   1909 K Street, N.W.
   Washington, D.C 20049

4. American Association of Homes for the Aging

Address: AAHA
1050 17th Street, N.W.
Suite 770
Washington, D.C. 20036

5. National Center on Black Aged

Address: NCBA
1424 K Street, N.W.
Suite 500
Washington, D.C. 20036

6. National Association for Spanish-Speaking Elderly

Address: Asociacion Nacional Pro Personas Mayores
3875 Wilshire Blvd.
Suite 401
Los Angeles, CA 90010

7. National Indian Council on Aging

Address: NICOA
P.O. Box 2088
Albuquerque, NM 87103

SECTION VI

ANNOTATED BIBLIOGRAPHY

This section briefly reviews books and articles that are frequently cited in discussions about financing long term care programs. Some of the pieces are of particular relevance to gerontologists and planners interested in long term care, others are not. The annotations make clear which pieces should be read.

Bishop, Christine. "A Compulsory National Long Term Care Insurance Program," in Reforming the Long-Term Care System: Financing and Organizational Options. Edited by Stanley Wallack and James Callahan. Lexington, Mass: Lexington Books, 1980.

In this paper the author presents a discussion of a little discussed option for changing the financing of the long term care system: the development of an insurance approach to long term care.

The first section of the paper is devoted to a discussion of the basic principles of insurance. The author concludes that the problem of disability-related long term care expense can appropriately be treated as an issue of insurance. Two models of benefit recovery are presented. Under the first model, benefits are provided strictly on the basis of disability. Under the second model, benefits are contingent not only on the occurrence of disabilities but are also contingent on other factors such as the availability of informal supports.

The second section of the paper is devoted to a discussion of why private insurance markets have failed to produce long term care policies. The possible reasons discussed here include low demand caused by the discrepancy between income and necessary premium over the life cycle, the current lack of availability of public programs, adverse selection, moral hazard, administrative diseconomies, and uncertainties of expected payment due to inflation. The author concludes that the only insurance approach that would be feasible would be a mandatory public program. Pursuant to this conclusion, the author discusses the very difficult issue of determining the quantity and method of recovery. The possible role of co-payments is then discussed and the paper concludes with an overview of some possible impacts of a national long term care insurance program.

Since the major thrust of this paper is at the national policy level, it may not be as directly relevant to Long Term Care Gerontology Centers as other papers presented in these annotations. Nevertheless, the paper does represent some very clear thinking on a policy option that has been much neglected.

Butler, Patricia. Financing Non-Institutional Long-Term Care Services For The Elderly and Chronically Ill: Alternatives to Nursing Homes. Washington, D.C.: Legal Services Corporation, (n.d.)

This paper is designed to provide an issues-oriented basis from which to argue for expansion and changes in the financing of non-institutional long term care services to the elderly. The paper is written by an attorney and has as its primary audience advocates for the elderly. While the paper develops an aggressive posture towards service expansion, the meticulousness with which it reviews service programs, identifies areas of possible change, and develops arguments recommends it to a wider audience; it is important reading for gerontologists as well.

As part of an overview, the paper introduces several major Federal-State service programs: Medicare, Medicaid, Title XX-Social Service, Veterans Administration, and Housing, with primary emphasis on the first three programs. The author examines the program structure, service universe, and eligibility requirements. Differences among the programs are noted. Financing of services under these programs is also detailed.

One of the author's chief concerns is to develop possible legal, administrative, and legislative arguments that will lead to service expansion. Personal care services and rural health clinic services under Medicaid, and home health care under both Medicare and Medicaid, are carefully examined. Topics such as eligibility qualifications, provider limits, limits on amount of service, prior authorization and reimbursement receive particular attention in the context of legislative intent and state implementation. The likelihood that challenges for expansion will be successful is also discussed. Cursory attention is paid to the cost-effectiveness of alternative services and to specific examples of state-developed initiatives.

This paper focuses primarily on national level issues and is designed to augment more detailed analyses of programs within individual states. It is a well developed piece, and one that organizes in a clear fashion many of the disparate issues surrounding the financing of non-institutional services.

Davidson, Stephen M. and Marmor, Theodore, R. The Cost of Living Longer: National Health Insurance and the Elderly, Lexington, Mass.: Lexington Books, 1980.

The main purpose of this book is to evaluate the probable impacts that various national health insurance (NHI) proposals would have on health services for the elderly. In particular, the authors examine eligibility criteria as they affect the elderly, benefits packages, and program administration.

The authors are to be commended on the approach they take to the subject. They spend most of the book describing and evaluating the current financing system of health care for the elderly. They go into great detail about eligibility provisions, benefit structures, and administration of Medicare and Medicaid. Their analyses point out the great horizontal and vertical inequities and great regional variations in the Medicaid systems, the lack of long term care coverage under Medicare, and the nature of Medicare/Medicaid buy-in components. This in-depth discussion of current programs puts the reader in an excellent position to evaluate proposed system changes.

The book goes on to describe several prototypal NHI proposals and compares each to the current system (Medicare/Medicaid). The author concludes that any of the major NHI proposals would do a better job of providing medical services to the elderly then does the current system. Unfortunately, the book does not discuss recent long term care proposals, nor does it discuss the importance of the interface between health care and social service financing systems. Nevertheless, the book will be of great value to individuals who are interested in learning more about the intricacies and anomalies of the current system.

Diamond, Larry M. and Berman, David E. "The Social/Health Maintenance Organization: A Single Entry, Prepaid, Long-Term Care System," in Reforming the Long-Term Care System: Financing and Organizational Options, Edited by Stanley Wallack and James Callahan. Lexington, Mass.: Lexington Books, 1980.

This paper represents the most comprehensive work currently available on the development of prepaid (capitated) long term care systems. The paper begins with a discussion of the conceptual rationale for prepaid long term care models. As part of this discussion, the authors discuss the organizational entities that show the most potential for developing these prepaid models. Possible variations in the model are then discussed. Organizational auspices and form, financing alternatives, and service options are discussed.

With the basic concept developed and various generic variations discussed, the authors go on to present a discussion of several important issues that must be resolved. These include questions of marketing, quality of care, political acceptability, risk management, and target populations. The body of the paper concludes with an implementation strategy. Center staff will also be interested in reviewing the appendices of the paper, in which the authors present a brief discussion of the providers now working on the S/HMO concept with the University Health Policy Consortium.

As mentioned above, this represents the current state of the art with regard to prepayment for long term care. Centers seriously considering the possibility of developing or helping others to develop such a model are encouraged to read the paper.

Feder, Judith and Holahan, John. Financing Health Care for the Elderly: Medicare, Medicaid, and Private Insurance. Washington, D.C.: The Urban Institute, February 1979.

This monograph was prepared by The Urban Institute for the U.S. Department of Health, Education, and Welfare's Administration on Aging. Using data from several sources, the authors identify gaps in the current funding of medical services for the elderly under Medicare, Medicaid, and private insurance. The monograph then attempts to gauge utilization and to estimate the actual cost burden these gaps impose on the elderly. The monograph provides background discussions with some good presentation of several data sources. It is not, however, required reading.

The familiar Medicaid gaps discussed include: the 90-day limit on inpatient hospital stays per benefit period, the 100-day SNF limit, the 3-day prior hospitalization requirement for home health care, and uncovered services. However, the monograph's real contribution is that it attempts to develop utilization profiles, estimate the impact of deductibles (currently $180) in the context of these profiles, and ascertain the actual impact on the elderly person.

Data shows that 19-23 percent of all Medicare enrollees use Part A hospitalization services each year, 2 percent use skilled nursing care, and 78-82 percent use Part B services. Using several secondary data sources, the monograph shows that only a small portion of the elderly incur liabilities for co-insurance, and even fewer exhaust all of their benefits. They also show that nursing home users were far more likely to incur cost sharing than were inpatients. In

view of these data, and analysis of physicians' charges, uncovered services such as drugs and glasses, and nursing home charges, the authors argue suggest that a significant proportion of Medicare enrollees incur substantial liabilities.

The authors also indicate that Medicaid-Title XIX and private insurance offset some of the burden for the very poor and for higher income groups, respectively. Nonetheless, the very poor seem to spend a substantial portion of their income on medical care.

In the second part of the monograph, the authors discuss private health insurance for the elderly. They argue that while variations in coverage, limits, and costs makes comparisons difficult and though the insurance is more likely to cover hospital deductibles than uncovered hospital services, half the elderly have some protection against out-of-pocket expenses. The second part of the monograph does provide a good introduction to some of the concerns about health insurance coverage among the elderly. This discussion, together with the more recent Congressional Budget Office's Profile of Health Care Coverage: The Haves and the Have Nots (March, 1979), gives an excellent introduction to gaps in private health insurance coverage.

Fullerton, William, D. "Finding the Money and Paying for Long-Term Care Services--the Devil's Briarpatch." Paper prepared for Symposium on Long-Term Care Policy Options, June 11-13, 1980, at Williamsburg, Virginia. (Draft paper to be published. For copies contact Judith Meltzer, School of Social Service Administration, University of Chicago, Phone 312/753-4655.)

In this paper the author discusses and evaluates several possible mechanisms that could be used to fund long term care services. He also discusses, to a limited degree, several types of reimbursement schemes to pay for these services.

In the first part of the paper, the author sets up and discusses the criteria to be used in evaluating funding sources. These criteria include: inflationary impact, extent of income redistribution effects, effects on growth of the program over time, effects of the financing source on resource creation, ease of administration, and political acceptability. The sources of financing reviewed include: payroll financing on a prepaid bases, use of Federal general revenues (for both open-and closed-ended programs), value added tax, tax on tobacco and alchol, prepaid contributions from eligibles with tax deductions and tax credits. The paper then discusses the advantages and disadvantages of reimbursement based upon fee-for-service, capitation payments, and vouchers.

The author concludes that:

- o Existing sources of public funds for long term care services can at best be maintained at current levels - with little future increase;
- o Government should encourage increased private spending for long term care and should find new forms of public financing;
- o In both financing of and reimbursement for long term care, housing for the aged has important impacts which should not be ignored; and
- o Expenditures will get out of control unless total expenditures are limited in some fashion.

The paper concludes with a rather creative proposal for funding long term care which incorporates private insurance, tax incentives, and a public lottery. While the paper does not address the problems of the current system, it does provide a very good overview of public finance issues as they relate to long term care. The paper addresses itself to a general audience and virtually no background in public finance is required. Staff of the Long Term Care Gerontology Centers will find this a useful document.

Tom, Joe, and Meltzer, Judith. "Policies and Strategies for Long-Term Care," Health Policy Program, University of California, San Francisco, May 14, 1976. (mimeo)

Although the data presented in this paper are somewhat dated, it still stands as one of the most comprehensive overviews of long term care policy. The authors present a discussion of the current system and its limitations and shortcomings. Problems discussed include:

- o The presence of an institutional and medical care bias in the flow of public funds for long term care;
- o An unclear and confusing array of inter-governmental roles in finance, administration, and delivery of long term care services;
- o Lack of community placement and delivery systems;
- o Lack of client choice; and
- o Limited accountability at all levels of government.

The paper concludes with a set of recommendations that encompass six general areas:

- o Detailed data collection and problem analysis
- o Technical/administrative reforms
- o Long term care financing
- o Delivery systems: community assessment, placement referral and feedback mechanisms
- o Manpower, training and development
- o Research and technological development.

The authors' recommendations with regard to financing will be of particular interest to Long Term Care Gerontology Centers which are considering developing demonstration projects using 1115 or 222 waivers. The authors recommend the development of a three part financing strategy:

- o Establishment of a Federally financed program to cover the cost of room and board in long term care facilities.
- o Amendments to existing social service programs to make flexible provision for meeting long term care service needs (regardless of place of residence).
- o Continued funding for medical services through Medicaid and Medicare, or national health insurance.

Kane, R.L. and Kane, R.A., "Care of the Aged: Old Problems in Need of New Solutions." Science 200 (May 1978): 913-919.

This short, well-written article not only provides a good overview of some of the major problems associated with long term care in the United States; the authors suggest several system reforms that should be of great interest to persons associated with Long Term Care Gerontology Centers.

In particular, the authors discuss the problems associated with the use of a medical rather than a social service model of care in nursing homes, the overreliance on institutional care, the lack of funding for non-institutionally based long term care services and reimbursement that is not related to outcomes. As part of this discussion, the authors present several international examples and comparisons.

It is clear from subsequent writings by these authors that their principal recommendation is the development of a public financing system that reimburses providers on the basis of client outcomes. Equally important, however, is their call for the development of a locally planned and controlled long term care delivery system, a system of care in which financial incentives make the nursing home is the last--not the first--line of defense.

Marmor, T.R. "The Question Remains: Is Universal Government Health Insurance Desirable?" Generations (May 1980).

Although not directly related to the day-to-day concerns of Long Term Care Gerontology Centers, this article provides a short introduction to some of the political issues that continue to surround the debate over national health insurance.

The author presents a useful classification of national health insurance proposals in terms of their scope of benefits and source of financing. He suggests that, due to our current economic situation, improvements in national health insurance for the elderly will require fierce competition with other interest groups. The author further suggests that due to administrative arrangements and benefit coverage of most of the proposed national health insurance plans, the elderly would be better off than under the current fragmented financing system. However, he does not discuss the potential dangers of consolidating long term care under medically-oriented legislation. Thus, the question still remains, should long term care be part of national health insurnce or should it be a separate program?

The reader interested in pursuing the topic is referred to Davidson, J., & Marmor, T.R. The Cost of Living Longer: National Health Insurance and The Elderly.

Morris, Robert, "Completing the Health Care System Through Personal Care Benefits." International Journal of Aging and Human Development, Vol. 4, No. 2, 1979.

This article represents an early attempt to develop a model program and funding mechanism that would provide for the broadly defined health needs of the elderly. Testifying to its innovativeness, the program model that it lays out has since been embodied in several Federally-sponsored long term care demonstration projects. Additionally, the voucher funding mechanism that it proposes is currently being developed and tested in a Health Care Financing Administration project in Illinois. Accordingly, its importance to gerontologists is chiefly as a historical document.

The PCO program and funding model directly address problems of fragmented financing and delivery systems and uneven programming. The article develops only the outline of these ideas. Morris admits considerable more work needs to be done.

The program model that Morris proposes is centered around the "Personal Care Organization (PCO)." Premised on the belief that health problems of the elderly encompass social and maintenance needs as well as those related to medical treatment, the PCO would offer a wide range of services such as home nursing, meals, information, shopping, transportation, etc. The approach proposes to balance active medical treatment with personal and social services.

Morris also proposes a cash transfer or voucher system of payment with the client being chiefly responsible for choosing services and initiating provider contact with the PCO. The voucher system would be an entitlement, with the amount related to an individual's level of disability.

Pollak, William. Expanding Health Care Benefits for the Elderly: Volume 1. Long Term Care. Urban Institute Health Policy and The Elderly Series. Washington, D.C.: The Urban Institute, 1979.

This paper discusses the issues that arise in the expansion of long term care coverage for the elderly. It attempts to answer questions about which services should be expanded, who should receive and provide them, who should pay for them, and who should administer them. By design, the paper is a wide-ranging one. It has, however, several important parts.

The four main areas covered are the nature and scope of services, the nature of the service organization, the cost of services, and the location of authority for the program. These areas are discussed in the context of how to broaden coverage.

A chapter on the organization of the provision of long term care contains a good discussion of entitlement versus fixed budget financing. Pollak discusses these approaches in the context of the need for cost containment and the need to maintain informal, family support systems while equitably allocating services. He also argues that the funds should flow through the consumer rather than the provider agency or vendor. These discussions are recommended reading.

Addressing financing from the consumer side, Pollak also discusses cost sharing. He argues that variables such as family status, income, and assets are important

considerations in determining where the burden of care should be placed. The chapter includes an examination of several cost sharing formulas. The book concludes with a discussion of where the locus of departmental responsibility for long term care should be placed.

Sager, Alan, "Utilization and Costs of A Comprehensive National Long-Term Care Plan." Waltham, Mass.: Brandeis University, 1976.

This paper was prepared in September 1976 for the staff of the Congressional Budget Office and attempts to estimate the cost of a particular piece of legislation in the 94th Congress: H.R. 2268, the Rep. Barber Conable - Medicare Home Care Program.

The proposed legislation would create a voluntary Part D under Medicare with money to be channelled through the states to newly established Community Care Organizations (CCOs). The CCOs would provide or purchase home health care, homemaker services, personal care, day care, foster care, congregate living, nursing home care and outpatient community mental health services. Sager analyzes the services proposed by the legislation and estimates utilization and costs.

The article has limited appeal. Its chief value is an example of a quasi-technical discussion of cost estimation for national policies. As such, it shows the difficulty that confronts analysts doing such work, for there is little hard data on client utilization, need, and outcomes on which large scale projections might be based.

Winn, Sharon, and McCaffree, Kenneth M. "Issues Involved in the Development of a Prepaid Capitation Plan for Long Term Care Services," The Gerontologist, Vol. 19, No. 2, 1979.

In this paper, the authors discuss the issues and ramifications of establishing an alternative method for financing of long term care services. The authors propose the development of prepaid capitation plans for long term care services. The authors discuss the possible advantages of capitation over the current fee-for-service system, the differences between a capitation payment plan for long term care and capitation plans presently in existence, alternative approaches in developing a capitation plan, and the likely impact on cost and utilization of such plans.

Center staff not familiar with the HMO literature or the basic issues of capitation for long term care will find this piece useful. The paper is not technical and is written for a general audience. Furthermore, the capitation approach to financing may well be an interesting topic of study and development that some centers will want to pursue.

U.S. Congress, Congressional Budget Office. Long-Term Care for the Elderly and Disabled. Budget Issue Paper, February 1977.

This widely circulated report provides an introduction to problems in the current long term care system and a set of three options for change. While much of the discussion can be found elsewhere, the final chapter that develops the three options for change should be read.

By way of introduction, the services being provided and who is receiving them are discussed. Additionally, some care is taken to project future demand for services. The second chapter estimates gaps in coverage and derives an unduplicated estimate of actual coverage. The chapter also contains a decent review of previous studies on the cost of inappropriate nursing home placement in the existing system.

Following a brief discussion of problems and inadequacies in the current system, the report develops three policy options:

A. Modification of Existing Programs
B. Long Term Care Insurance - Entitlement
C. Comprehensive Long Term Care Grant

The final chapter discusses these options with cost estimates for each. Option A proposes eliminating the homebound requirement and expanding services under Medicare. Under this option, Medicaid home health services would be mandatory. Option B would develop a long term care entitlement program for all aged and disabled persons. The option is basically a social insurance program. Eligibility would be handled through special long term care centers. This is the most expensive of the options described. Option C would include the Medicare changes described in Option A, but would also channell all Medicaid and Title XX funds through a single semipublic agency. The grant would be closed-ended and would provide for a local administrative focus with a uniform set of services.

U.S. Congress. House. Subcommitte on Health and Long-Term Care of the Select Committee on Aging. "Medicare Gaps and Limitations." 95th Cong. 1st. session, 1977.

Testimony at these hearings before the Select Committee on Aging, chaired by Congressman Claude Pepper, was presented by five witnesses: John B. Martin, National Retired Teachers Association/American Association of Retired Persons; Sidney Stindell, Association of Teachers of Preventive Medicine; Hilda Robbins, Mental Health Association; Sammy Griffin, National Federation of Licensed Practical Nurses; and Stephen Sund, from Putnam County, NY.

The testimony concerns itself with pointing out gaps in the current coverage under Title XVIII-Medicare, suggesting possible remedies, and dramatizing the need for legislative action. The gaps and problems discussed are the drug costs under Part B, the need for preventive services aimed at long term chronic health problems in the elderly instead of acute episodes treatment, the structured biases of the program against services to the mentally ill elderly, the bias towards institutional treatment, and the economic burden imposed by the cost-sharing requirements of the program. Though little of the testimony cannot be found elsewhere in other forms, the narrative is interesting. However, the discussion (with appendices) of problems in serving the mentally ill elderly is recommended as a concise summary. It presents detailed information concerning the biases and problems that the law creates.

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FOOTNOTES

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SECTION II

1. Butler, Patricia Financing Non-Institutional Long-Term Care Services For The Elderly and Chronically Ill: Alternatives to Nursing Homes, Legal Services Corporation, (undated), p. 16.

2. Ibid, p. 17.

3. Feder, Judith and Holahan, John Financing Health Care for The Elderly, Urban Institute, February 1979, p. 2

4. Ibid.

5. See "Medicare Gaps and Limitations." Select Committee on Aging, U.S. House of Representatives (Comm. Publ. No. 95-116), October 18, 1977, Statement of Hilda Robbins for the Mental Health Association, pp. 59-62.

6. Butler, p. 16.

7 Davidson, Stephen M., and Marmor, Theodore R. The Cost of Living Longer, Lexington Books, p. 39.

8. Butler, pp. 16-20.

9. "Medicare Gaps and Limitations," p. 61.

10. See Feder and Holahan discussion, pp. 17-19.

11. Federal Register 45210 (September 29, 1978) contains most Medicaid regulations. See also Feder and Holahan, p. 35, and Davidson and Marmor, p. 15.

12. Davidson and Marmor, pp. 15-16.

13. See 45 CFR 435.731 through 435.170.

14. Davidson and Marmor, p. 71, contains a good discussion of the spend-down process.

15. See 45 CFR 440.10 through 440.170.

16. Butler, p. 24.

17. Copeland, William C. Finding Federal Money for Children's Services, Child Welfare League of America, 1975, p. 3.

18. DHEW, Report of the DHEW Interagency Task Force on Long-Term Care, (undated), Appendix 11, p. 5.

19. Butler, p. 35.

20. 45 CFR 228.56.

21. Copeland, pp. 13-16.

22. Report of the DHEW Interagency Task Force, Appendix 11, p. 10.

23. Ibid, p. 13.

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1. Feder, Judith and Holahan, John Financing Health Care for the Elderly, The Urban Institute, 1979, p. 20.

2. Congressional Budget Office (CBO) Long-Term Care for the Elderly and Disabled, February 1977.

3. Joe, Tom and Meltzer, Judith "Policies and Strategies for Long-Term Care," Health Policy Program, University of California, May 14, 1976.

4. Davidson, Stephen and Marmor, Theodore The Cost of Living Longer, Lexington Books, 1980.

5. CBO, p. 18.

6. Butler, Patricia Financing Non-Institutional LTC for the Elderly and Chronically Ill: Alternatives to Institutionalization, (n.d.), pp. 26-28.

7. CBO, p. 28.

8. Butler, p. 27.

9. See Feder and Holahan, p. 24 ff.

10. Davidson and Marmor, p. 27.

11. CBO, p. 29.

12. Scanlon, "A Theory of the Nursing Home Market." Inquiry 17 (Spring 1980): 25-41.

13. Bishop, Nursing Home Behavior Under Cost-Related Reimbursement, Discussion Paper DP-9, University Health Policy Consortium, Boston, MA, 1980.

14. CBO, p. 11

15. Ibid, p. 24.

16. Farrow, Frank "Policy Options for Long-Term Care of the Elderly." Draft of proposal of the Center for the Study of Welfare Policy of the University of Chicago to the Administration on Aging, 1978, p. 6.

17. See "Future Direction for Aging Policy: A Human Service Model." Select Committee on Aging Report (Publ. No. 96-226), May 1980, p. 28. The programs identified in this document are listed below:

Federal Programs Benefiting the Elderly

Health Care

Community Mental Health Centers
Construction of Nursing Homes and ICFs
Medicaid
Medicare
VA Domiciliary Care Program
VA Nursing Home Care Program

Housing

Housing for the Elderly (Section 202)
Low and Moderate Income (Section 8)
Mortgage Insurance (Section 231)
Rural Rental Housing (Section 515)
Community Development
Low Rent Public Housing
Rural Home Repair (Section 504)
Rural Rental Assistance (Section 521)

Employment

Age Discrimination in Employment
CETA
Community Service Employment for Older Americans
Employment Programs for Special Groups
Foster Grandparents Program
Retired Senior Volunteer Program
Senior Companion Program
Service Corps of Retired Executives
VISTA

Income Maintenance

Civil Service Retirement
Food Stamps
Social Security
SSI
Veterans Pension Program

Social Service Programs

Crime Prevention (LEAA)
Educational Opportunities for Older People
Legal Services Corporation
Multipurpose Senior Center Facilities
Nutrition Programs
Revenue Sharing
Senior Opportunities and Sharing
Title XX
Title III

Training and Research

Model Projects
Multidisciplinary Centers of Gerontology
Personnel Training - Title IV-OAA
Research on Aging

Transportation

Capital Assistance Grants for Use By Public Agencies
Capital Assistance Grants for Use by Private non-Profit Groups
Reduced Fare Program
Capital and Operating Assistance Grants

18. Ibid, p. 31. (From Office of Management and Budget)

19. "Impact of the Fiscal Year 1980 Budget on the Elderly," Select Committee on Aging Hearings (Comm. Publ. No. 96-182), February 7, 1979, p. 81.

20. It is worth noting that the timing of actual expenditure reports varies widely by program. In many instances, current budget appropriation figures are more useful indicators.

21. Budget of the United States Government, Fiscal Year 1981, Appendix, Office of Management and Budget, pp. 470-472.

22. Medicaid Management Institute, Data on the Medicaid Program, 1979, p. 40.

23. Butler, p. 25.

24. Ibid, pp. 35-36.

25. Select Committee on Aging, (May 1980), p. 64.

26. See Butler, p. 36.

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2. Ibid, p. 39.

3. DHEW, Home Health and Other In-Home Services: Titles XVIII, XIX and XX of the Social Security Act, A Report to Congress, October 1979. Summarized in Judith Meltzer and Frank Farrow, Federal Policy Directions in Long-Term Care, Center for the Study of Welfare Policy, University of Chicago, May 31, 1980, p. A-1

4. CBO, pp. 40-45.

5. Meltzer, Judith and Farrow, Frank, Federal Policy Directions, p. A-6.

6. Bishop, Christine E., "A Compulsory National Long-Term Care Insurance Program," in Stanley Wallack and James Callahan, Reforming the Long-Term Care System: Financing and Organizational Options, Lexington Books, 1980.

7. CBO, pp. 45-48.

8. Hudson, Robert B., "Restructuring Federal State Relations in Long-Term Care: The Block Grant Alternative," in Stanley Wallack and James Callahan, Reforming the Long-Term Care System, (July 1980 draft), p. 2.

9. H.R. 14453 in the 94th Congress, 2nd Session.

10. Meltzer, Judith and Farrow, Frank, p. A-3.

11. Ibid, p. A-5.

12. Diamond, Larry M. and Berman, David E., "The Social/Health Maintenance Organization: A Single Entry, Prepaid, Long-Term Care Delivery System," in Stanley Wallack and James Callahan, Reforming the Long-Term Care System.

13. Information in this section is abstracted from Appendix B in Stephen M. Davidson and Theodore R. Marmor, The Cost of Living Longer, Lexington Books, p. 128 ff.

14. Ibid.

15. Fullerton, William D., "Finding the Money and Paying for Long-Term Care Services — The Devil's Briarpatch," Paper #3 for Long-Term Care Symposium, Center for the Study of Welfare Policy, University of Chicago, January 1980.

16. Joe, Tom and Meltzer, Judith, Policies and Strategies for Long-Term Care, Health Policy Program, University of California, May 14, 1976, pp. 23-24.

APPENDIX 1

THOUSAND ISLANDS CONFERENCE PARTICIPANTS

Eugene M. Dagon, M.D.
Medical College of Wisconsin
9191 Watertown Plank Road
Milwaukee, WI 53226

Charles Fogelman, Ph.D.
8711 Maywood Avenue
Silver Spring, MD 20910

Margaret Gatz, Ph.D.
734 W. Adams Blvd.
Los Angeles, CA 90007

Jay Greenberg, Sc.D.
Associate Director
Health Services Research Center
University of Minnesota
1350 Mayo Building, Box 197
420 Delaware Street, S.E.
Minneapolis, MN 55455

John A. Hackley, President
The Hillhaven Foundation
P.O. Box 99237
Tacoma, WA 98499

Tom Hickey, Dr.P.H.
Health Gerontology Program
M5112 School of Public Health
University of Michigan
109 S. Observatory
Ann Arbor, MI 48109

Gail House, Ph.D.
Southwestern Gerontological Institute
Texas Tech University Health
Science Center
Thomas Hall, Room E-118
Lubbock, TX 79430

Glenn H. Hughes, Ph.D.
Medical Towers Building
1717 11th Avenue, South
Birmingham, AL 35294

Richard A. Kalish, Ph.D.
1010 Idlewilde Lane, S.E.
Albuquerque, NM 87108

Rosalie Kane, D.S.W.
The Rand Corporation
1700 Main Street
Santa Monica, CA 90460

Donna Lind, Ph.D.
Department of Health Services
Administration
George Washington University
Washington, D.C. 20052

Myron Miller, M.D.
Veterans Administration Medical
Center
300 Irving Avenue
Syracuse, NY 13210

Russell Mills, Ph.D.
University of Kansas Medical Center
134 Sudler
39th and Rainbow
Kansas City, KS 66103

Michael Smyer, Ph.D.
S-110 Human Development
Pennsylvania State University
University Park, PA 16802

For ELM Services:

David J. English, D.B.A.
Lee E. Mortenson
Celia Berdes
Kathleen Grady